



Coconino County Juvenile Detention Grievance/ Complaint Form

Name of Youth _____ Name of Individual Filling out Grievance _____

Date of Incident _____ Time of Incident _____

Date of Report _____ Time of Report _____

Please list the names of everyone involved

1.	2.	3.
4.	5.	6.

Please explain what happened (who, what, when where, how)

Please Explain your thoughts/ feelings about the incident

What is your desired outcome from this report?

A Detention Supervisor/ Youth Care Worker V or the Assistant Detention Manager will get back to you to discuss this report within 48 hours. If you are unsatisfied with the response, decisions and or actions taken by the Detention Supervisor/ Youth Care Worker V or Assistant Detention Manager, you may appeal to the Detention Manager. The Detention Manager will respond to the appeal within 48 hours.



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For Staff use only

Grievance Tracking Number _____ Received Date _____

Received Time _____ Received by _____

Was the Incident discussed with youth prior to the grievance being completed? YES NO

If yes when was it discussed and with whom?

Detention Supervisor /Youth Care Worker V or Assistant Detention Manager follow up report.

Date of meeting with youth _____ Time of meeting with youth _____

Notes

Decided Outcome

Staff Name _____ Signature _____

Youth Name _____ Signature _____

Do you wish to appeal to the Detention Manager? YES NO

Detention Manager Signature _____ Date _____